iCircle Services MLTC Timely Filing Overview

* All Providers (and subsequent staff or outsourced programs, billing or otherwise, who require such insight) prior to and during the execution of contract, and during the onboarding process, shall refer to their specific iCircle MLTC (& additional lines of business if applicable) contract to confirm timely filing agreements for submission of claims, authorization requests/revisions, corrections, appeals, etc. to determine if their specific contract differs from the below outline of iCircle MLTC timely filing guidelines. <u>The executed provider contract overrules all of the below information if different in any way.</u>

iCircle MLTC Standard Timely Filing Guidelines

<u>**Original Primary Claims:**</u> Providers have 120 days from the original date of service (DOS) to submit a CLEAN claim to iCircle MLTC via Clearing House 835 file (Electronic Submission) or via postal in which case the date of submission will be the date in which iCircle MLTC receives the postal claims to the below address:

iCircle Care
P.O. Box 1320
Webster, NY 14580
ATTN: Claims Department

- Electronic Claims are to be sent via Clearinghouse to:

  Clearinghouse: Visibiledi
  Payer Name: iCircle
  Payer ID: ICRCL
  Authorization Number: Provided on Authorization from iCircle
  Member Account Number: Provided on Authorization from iCircle (Medicaid #)

- It is highly suggested, if submitting via postal, to mail via *certified mail receipt* and to have consistent internal records of what specific claims were sent within each mailing batch. In the case that any claim is misplaced in the mail or not entered due to any unforeseen error by either party, the above records can prove valuable if needing to submit an appeal to override timely filing. Sufficient proof of claim submission within the timely filing guidelines must be provided if looking to overturn a timely filing denial.
- Providers may also submit electronic files, or via Direct Claim Entry, by utilizing iCircle's Provider Portal. For Provider Portal Assistance, please inquire with our Provider Network Team

Secondary Claim Submission: Claims must be submitted no later than 120 days from the date of receipt of the primary EOB to your organization. (Dates will be on the Primary EOB, which should be submitted in full, along with the secondary claim to iCircle MLTC)

Corrected Claim Submission: Corrected Claims must be submitted no later than 12 months from the date of service via the same submission methods as outlined above. Corrected claims must include some portion of the claim data that needed correction (a claim that is resubmitted without any change in claim data will NOT be considered a corrected claim).

- Original Claims must have fully processed (Provider Receives EOB) prior to corrected claim submission. Failure to adhere to this aspect will result in a rejection/error on the corrected claim, which will prevent from processing. It is the provider's responsibility to not submit corrected claims until their original claim has fully processed.
- Please note; a REJECTED claim is not the same as a Denied Claim. If your claim was rejected, it will be sent back to you (or not allowed to rejected via clearinghouse if attempting to send electronically) in which case your next submission will still be considered an ORIGINAL claim, and thus follow the original claim timely filing guidelines. Denied claims will reflect on a remit/EOP to your organization while rejections will not. A rejection will occur if the claim does not have all needed items in order to process the claim within the iCircle claims/billing system (common rejections include missing provider information, missing member information, etc.)

Filing a Claim Appeal / Reconsideration: Appeals / Reconsideration requests must be submitted no later than 90 days after the denial / payment of the original claim; and must use the iCircle MLTC Appeal form.

- Providers shall not submit claim appeals until the original claim has processed fully.

PLEASE NOTE: Submission of a claim dispute via a grid or email to the Provider Service / Provider Relation's Team, where provider disagrees with a claim determination, is considered an **APPEAL** and therefore must be within the appeal timeframe of 90 days from date of remit. Inquiries of this nature that are past 90 days from the remit date must include sufficient reasoning as to why the inquiry is past timeliness for appeals or the claim will be considered closed/final.

If you have any questions pertaining to timely filing, claim submission, corrections, appeals or otherwise, please call our Provider Network Team at 1-844-283-2884, or you may email our provider hotline at ProviderService@iCirclecny.org